

# REPORT FROM THE FIELD

## Mission Not Yet Accomplished? Massachusetts Contemplates Major Moves On Cost Containment

After filling coverage gaps, Massachusetts reformers turn their attention to containing costs. Would a new global payment system transform this medical mecca?

by Martha Bebinger

**ABSTRACT:** There is growing concern in Massachusetts that rising health care costs will derail the state's move to universal health coverage. A special state panel has recommended moving from fee-for-service to a new system of global payments as the best way to reduce unnecessary care and expenses, while improving the health of patients. The commission points to specific examples in the state where global payments seem to be working. But other providers are pushing back. [Health Aff (Millwood). 2009;28(5):1373-81; 10.1377/hlthaff.28.5.1373]

**H**EALTH REFORM IN Massachusetts is the health reform that many outside the state love to hate. There is too much government intervention for conservatives; for liberals, government doesn't go far enough. But by devising a compromise that, at least so far, has kept everyone at the table, Massachusetts has come closer to universal coverage than any another state in the country. The reform, however, has one big Achilles' heel: rapidly rising health care costs threaten to scuttle hundreds of other programs in the state budget; impair employers' ability to offer coverage to workers; and undermine both the political support and the mechanics of the health reform itself.

So in July 2009, a special state commission agreed unanimously on a plan to salvage health reform and the state's finances. The strategy it proposed: connect the thousands of doctors in

the state into new health care networks—then charge them with managing patients' care under "global" payments. These would be an updated form of capitation—in effect, annual payments to provider groups to pay for the care of pools of patients—tied to new incentives to improve the quality of care.

The announcement had the expected effect in a state where unconstrained access to top academic medical centers could be seen as a local birthright. *Capitation* is still a dirty word to some hospitals and doctors in Massachusetts—the legacy of "managed care" in the 1990s and the real and perceived barriers erected to care. Moments after the announcement, commission members acknowledged that they were already feeling enormous pressure to go slow. But state Representative Harriett L. Stanley, cochair of a key state legislative committee on health care financing and

.....  
 Martha Bebinger ([marthab@bu.edu](mailto:marthab@bu.edu)) is a Nieman fellow at Harvard University. She is on leave from her position as the State House reporter for WBUR, the National Public Radio affiliate in Boston, Massachusetts.

a commission member, was stalwart. “The unanimous commission vote told me we have some cover,” said Stanley, who expects to co-sponsor a bill paving the way for global payments in the fall.

Stanley and other proponents of massive change to Massachusetts’ health care system point to another part of the state’s health care legacy: that a number of capitated health systems have had a long and proud history in Massachusetts. Longstanding health maintenance organizations (HMOs) like Harvard Community Health Plan, founded in 1969, are still around, albeit operating now under different names and forms. And systems like Mount Auburn Hospital in Cambridge and its allied independent practice association (IPA) of physicians have been working under a system of global payments for the past twenty years, improving care and holding down costs along the way. Now these proponents have spoken up and have given the commission reason to think that instituting a system of global payments broadly will work to restrain the rate of growth in costs.

### First Things First: Covering The Uninsured

Controlling health costs was only a sidebar conversation four years ago, as Massachusetts struggled to reach an agreement on coverage for the uninsured. The focus was on coverage because the state was backed up against a wall: the federal government was threatening to pull \$365 million in Medicaid matching funds unless the state stopped using the money in effect to provide free health care for the uninsured and instead nudged people into public or private health coverage. But as the state crafted coverage reforms, it seemed overly difficult and politically disastrous to take on cost containment at the same time. Liberals wanted to defer that discussion until later. Pragmatists argued that the covering the

uninsured shouldn’t be held hostage to the state’s inability to control health costs. They believed that if universal coverage were put in place first, a community of interests would be created to take on costs later.

By this year, however, the time to tackle costs had indisputably arrived. The state’s uninsurance rate was down to 2.6 percent—the lowest of any in the nation.<sup>1</sup> The burden of paying for increased health coverage has been spread proportionately among employers, in-

**“As the state crafted coverage reforms, it seemed overly difficult and politically disastrous to take on cost containment at the same time.”**

dividuals, and the government,<sup>2</sup> with the state’s share increasing annually by about \$88 million.<sup>3</sup> There was widespread concern that rising health care costs could derail this health reform experiment.<sup>4</sup> Premiums for family health coverage have risen 94 percent since 2000.<sup>5</sup> Health care spending in all its forms consumes half of the state

budget. Amid the nationwide recession and collapsing state revenues, the Massachusetts legislature scaled back health coverage for 30,000 low-income legal immigrants. Meanwhile, projections showed that health spending in the state was likely to double over the next decade, rising from \$63 billion this year to \$123 billion by 2020.<sup>6</sup>

### Controlling Spending In The Medical Mecca

If the handwriting on the wall was clear, however, the task of reining in costs was monumental. Jonathan Gruber, an economist at the Massachusetts Institute of Technology (MIT), says trying to control health care spending will be more difficult in Boston alone than just about anywhere else in the country. After all, in just one 200-acre area of the city, there are 12 medical institutions that hum with nearly 40,000 employees and a million patients a year. This small “neighborhood” generates roughly \$5 billion in revenue<sup>7</sup> a year, some of which funds research aimed at discovering the next breakthrough in treatment for conditions such as cancer or cardiac care.

Residents of this “medical mecca” revel in having world-class care a heartbeat away. On *U.S. News & World Report’s* list of the top ten U.S. hospitals, Boston has two—and one is frequently referred to jokingly by a riff on its initials as Man’s Greatest Hospital.

Even in Mecca, the faithful have sometimes had their doubts—and resentments. Some hospitals in the state, for example, have long grumbled that they get paid much less for the same types of care than a favored few receive. But until recently there was little public scrutiny of the billions of dollars that flow through the state’s health care sector. Then, in 2008, the *Boston Globe* launched an investigative series on hospital payments in Boston. It showed that some of the largest teaching hospitals receive 15–60 percent more in payments for the same services than their competitors elsewhere in the city and state receive.<sup>8</sup>

In effect, there had long been a tacit agreement that these academic medical centers performed such an important public service that they should be paid more, because the public would ultimately reap the benefits. But now, amid the interminable cost spiral, these higher payments didn’t look so palatable—or important. The obvious implication, however, was that any attempt to level payments would produce big winners and losers—and the losers would include the institutions that employ some of the most influential business and civic leaders in the city.

“Deregulation and lax government oversight have allowed the hospitals with the most clout to extract big increases from insurers while everyone else falls behind,” concluded the *Globe*.<sup>8</sup> Within weeks, a special commission that had languished since it was created by law six months earlier came roaring to life.

### **The Special Commission Begins Its Work**

The so-called Special Commission on the Health Care Payment System began work early this year amid calls for bold and dramatic change. Commission members representing the state’s medical society and hospital association, along with insurers, lawmakers, and ac-

ademics, reached quick consensus at their first meeting on saying goodbye to the status quo. They decided that the predominant payment model in the state, as elsewhere—fee-for-service—had to be shelved because of its innate tendency to encourage more care, regardless of need or effectiveness.

Almost as quickly, the commission settled on global payments as the new paradigm. The fact that agreement was reached so quickly on this approach took even some proponents by surprise. “I didn’t expect to get to global payments so quickly, especially with such a wide range of stakeholders,” says commission cochair Leslie Kirwan, who is also Gov. Deval Patrick’s secretary of administration and finance. “The fact that this group agreed so quickly makes me confident that global payments is the right model.”

The commission imagines that most doctors, community providers, and hospitals would form so-called accountable care organizations (ACOs)—a notion first put forward by Elliott Fisher, Mark McClellan, and others in articles in *Health Affairs*.<sup>9, 10</sup> These networks wouldn’t necessarily all look alike. Many would be built around one or more hospitals; others could be structured around multi-specialty physician groups.

These ACOs would reach agreement with health insurers over annual risk-adjusted payments to cover each plan member. Members would choose a primary care provider, as many in HMOs already do. The primary care provider and the other providers in the ACO would be responsible for meeting the patient’s needs within that capitated payment. At the same time, the payment would be tied to the ACO’s meeting a set of quality standards, such as appropriate prescribing of antibiotics, making sure patients receive regular cancer screenings, and administering aspirin and beta blockers after a heart attack.

A new independent state board or authority would be created to decide myriad questions involving ACOs: guidelines for setting global payments, and formulas for how providers and insurers would share risk and divvy up any savings. The board would also set time

lines for transitioning from fee-for-service to global payments and would draw up a schedule of interim rewards for providers and penalties for failure to move to the new payment system on schedule.

The commission also recommended support for the transition: education to help providers and others understand the issues; health data analysis to pave the way for new quality metrics; and some assistance with adopting statewide electronic health records (EHRs). (The state and federal governments had already passed laws effectively requiring providers to have EHRs by 2015, but it's widely agreed that the road to implementation could be rocky.)

Commission members freely admitted that they expect challenges—first, as the state legislature decides what to do with the recommendations, and second, as providers undertake the shift to the new payment structure. “There’s no doubt the fact that we’ve all pointed to global payments is easy compared to the transition,” special commission head Kirwan says.

But in embracing global payments, the commission was hardly suggesting adoption of an exotic, vaguely foreign payment model. In fact, to the surprise even of some commissioners, global payment or some related form of capitation had long since gained at least a small toehold in Massachusetts. About a fifth of the care provided by doctors in the state is paid for under this model. And in fact, one of the hospital networks that already operates under global payments—and thus could be a model ACO—is right across the river from Boston, in that humble home of Harvard and MIT called Cambridge.

### The Mount Auburn Hospital Experience

Mount Auburn Hospital, about a mile from Harvard Yard and just north of the famed Charles River, is in the last stages of a facelift. Crews are putting the final touches on an ele-

gant new “face”—a new addition and entrance—that belie the hospital’s age (it was founded in 1886). The gourmet coffee shop and spiffy private rooms have helped transform a hospital some dismissed as a sinking ship a decade ago. The operational and financial transformation has been even more impressive. Today Mount Auburn, which has a small Harvard Medical School teaching program with approximately 240 house staff and residents annually, earns a higher margin than do

half of the other teaching hospitals in the greater Boston area. Global payments, a network of local physicians, and careful management of patient care have all been central to the institution’s turnaround strategy.

Capitation has also been an avenue that Mount Auburn has pursued to boost its profile in the crowded land-

scape of Boston-area hospitals. The institution and its network of attending physicians, the Mount Auburn Cambridge Independent Physician Association (MACIPA), negotiated with local insurers on their first capitated contract in the late 1980s. “We think we’re very unusual,” says president and CEO Jeanette Clough. “We’re very familiar with the capitated risk market, and have only added to it while others let it go. I don’t know anybody else in the Boston area that is doing it at this depth.” Today, just over a third of the hospital’s revenues come through capitated payments from health plans.

Most of the roughly 350 physician-members of the Mount Auburn IPA, MACIPA, who are a party to these capitated arrangements, are in small group practices. As such, they offer a model for the many such groups across the state that now worry about the risk they would take on under a global payment system. Most of these small groups have no experience in setting a budget for an entire group of patients for a year at a time. There’s also concern that insurers may be reluctant to cover the losses of doctors or physician groups while

**“Capitation has been an avenue that Mount Auburn has pursued to boost its profile in the crowded landscape of Boston-area hospitals.”**

they learn the ropes of working under a new payment system. But MACIPA president Barbara Spivak says operating within a system of global payments is very feasible. “We’ve figured out a positive way to work with our physicians,” she says, “to keep costs reasonable, but provide very-high-quality care.”

■ **Physician payment.** Here’s how the system works. First, the hospital, physician groups, and health plans negotiate a budget for the coming year that reflects the ages and sexes of all patients in the population. During that year, participating doctors and the hospital are paid fee-for-service for treating patients. At the end of the year, a formula called a “health status adjuster” kicks in to adjust the budget up or down based on health status—that is, how sick or well the patients were. All health expenses for the patients are then counted against the adjusted global budget. If there’s money left over, the IPA keeps it and distributes the surplus among the doctors and Mount Auburn hospital.

Built into the distribution formula for any surplus are a series of carrots and sticks. For example, 15–20 percent of doctors’ share of any surplus is based on whether they meet as many as thirty different quality measures, including high patient satisfaction scores. Physicians can also lose some share of the surplus if they have missed any monthly meetings of the small physician groups they are assigned to—called “pods”—which are aimed at making sure primary care doctors and specialists agree on and coordinate patient care. And as a goad to make sure that physicians are doing their best to accommodate patients’ needs, the IPA can also withhold surplus dollars from doctors who stop accepting new patients.

■ **Assumption of risk.** Under this system, Mount Auburn Hospital and its physicians assume most of the risk—in fact, as much as 100 percent in the IPA—for working within their annual global payments. One exception is that

the system isn’t responsible for emergency care that a patient receives out of the hospital’s area; the health plans take the exposure there. But the system is exposed in other ways. Mount Auburn describes itself as a full-service health care system that can provide 95 percent of a patient’s needs. Still, in and around Boston, patients are free to go to any hospital, at no additional personal expense. Physicians in the system also refer patients who need organ transplants, specialized neurosurgery, and treatment for some rare forms of cancer to other Boston-area hospitals as well. When patients receive care at other hospitals, Mount Auburn has to subtract those costs from its global payment. At the moment, that adds up to about 20 percent of all patient hospital costs.

Given the high degree of risk the system is exposed to,

what has occurred is actually something of a miracle: Mount Auburn and the doctors have actually come out on the winning end every year since they began working with a capitated model roughly twenty years ago. That’s encouraged the hospital and doctors to agree to expand the model as they’ve become more comfortable with taking on so much risk. Just in case, though, Mount Auburn also purchases reinsurance to protect itself in case patients’ expenses balloon beyond the global payments. The cost of that coverage is factored into the global budget.

The main reason that global payments work, says Dr. Spivak, is that the system has been motivated to invest money up front in care management and coordination. Taking aim at the costly problem of hospital readmissions, for example, Mount Auburn now employs case managers who conduct home visits with patients who’ve recently been discharged from the hospital. The case managers do home safety evaluations, checking for something as simple as whether there are slip-proof mats under rugs to prevent falls—a common and particularly dangerous injury for seniors.

**“The main reason that global payments work is that the system has been motivated to invest money up front in care management and coordination.”**

When a patient goes into a hospital for a hip fracture, Dr. Spivak notes, the cost can run \$40,000–\$50,000; by contrast, preventing the fracture costs about \$1,000, she says.

The shift to global payments has also produced a very different medical culture within the system—starting with primary care physicians, who are now at the front lines of managing patients' care in a way that is “completely upside down from the way a lot of other places are structured,” says Mount Auburn president and CEO Clough. In most health systems, specialists are in charge on the physician side, and the hospital runs its own show. “It takes a lot of different thinking on the part of the hospital to be at the mercy of a primary care network” and let doctors largely control risk-based contracts, Clough says.

■ **Differences from other settings.** Physicians who have worked at Mount Auburn and other Boston-area hospitals cite several differences. Rachel Haft is a primary care and infectious disease physician who works in a small practice with one other physician, a nurse practitioner, a medical assistant, and three office staff. She says that at Mount Auburn, she collaborates more freely and frequently with specialists about her patients and gets more feedback on the care she provides. That's uncomfortable for some physicians, but Dr. Haft says that she “would rather hear it from [her] colleagues than from an insurance company.”

At the same time, Dr. Haft values the support she gets from Mount Auburn Hospital and the entire IPA to practice better medicine. The system has an EHR that assists Dr. Haft and others in tracking patients' needs and progress. The system regularly disseminates guidelines and information about testing, medications, and new technologies. And the IPA helps Dr. Haft handle insurance and other reporting requirements and work with new quality measures. “You need a big, well-run institution to do all these things,” says Dr. Haft. She feels she has the best of both worlds: the ability to be in a small practice and have close relationships with her patients, yet still have the support of a much bigger system.

■ **Better communication.** A recurring theme among doctors at Mount Auburn is that being part of a system demands more and better communication. Chief of cardiology Kim Saal helped establish mandatory meetings and other systems at Mount Auburn to affirm the importance of sharing ideas and information. But ultimately, says Dr. Saal, Mount Auburn counts on a culture of providers who want to learn from the patient and each other. That's something, he says, you can't write into a health plan or payment system.

Patients also get the benefits of having close contact with their personal physician while still being part of a system. They get letters signed by their primary care doctors reminding them that it's time for a colonoscopy or a mammogram; few if any probably have any idea that these letters are generated en masse by the IPA through electronic review of patient records. When patients do see their physicians, they also get an earful about the importance of preventive measures. During recent office visits, Dr. Haft pushed one patient to try one more method to quitting smoking, and another to get a colonoscopy.

■ **Patients' stake in the system.** One “flaw in the system,” says Mount Auburn president and CEO Clough, is that patients are effectively insulated from the global payment system—and may have no stake in whether the system works. For example, since patients don't pay more if they seek care outside Mount Auburn, they face no disincentive to go outside the system—even though a new doctor or hospital may repeat tests or miss something in the patient's history or prescription list.

To stimulate more patient engagement in the system, Dr. Saal says, patients should be made to understand more about the cost implications of their care—for example, that a computed tomography (CT) scan they're seeking might not be the right test for them and might cost \$400–\$500. An improved global payment system, Dr. Saal says, should even require patients in the system to have advance directives, in hopes of heading off much of the expensive, ineffective care that patients receive in the last six months of life.

■ **Results.** In the final analysis, have global payments really helped lower costs and improve patient care at Mount Auburn? In fact, the reports made public to date on costs, patient outcomes, safety, and satisfaction show mixed results, as follows.

On hospital costs, Mount Auburn is in the middle of the pack—not as expensive as the area’s major teaching hospitals, nor as inexpensive as community hospitals in the region. For example, a stay at Mount Auburn for a common procedure such as removing a gall bladder typically costs Medicare 27 percent less than at Boston’s major teaching hospitals.<sup>11</sup> An x-ray at Mount Auburn is 31 percent less than at the area’s highest-cost teaching hospital, according to the state-run “My Health Care Options” Web site.<sup>12</sup> However, Mount Auburn is more expensive across the board than many community hospitals in the area, largely because it offers more intensive services.

Hospital readmission rates at Mount Auburn for people age sixty-five and older are 12–14 percent, compared to 18–20 percent nationally. On end-of-life care, Mount Auburn is again in the middle of the pack. According to the *Dartmouth Atlas of Health Care*,<sup>13</sup> the overall intensity of hospital care provided to Medicare beneficiaries is lower than that of some teaching hospitals but well above that of a comparable community hospital. Pharmacy spending in the system has increased at below-average rates. According to data from the Mount Auburn physician group, increases were 6.3 percent below statewide average increases in 2005, 0.75 percent below in 2006, and 3.3 percent below the national average spending increase in 2007 (statewide data from that year are not yet available). Screening rates for appropriate colonoscopies, mammograms, and pap smears rose two to four percentage points within the system during 2004–2006. MACIPA is in the middle among other Boston-area IPAs on the rate of screenings for diabetes,

heart disease, and several cancers. On Massachusetts state patient satisfaction scores, MACIPA’s ten group practices are generally above average. They are in the top 15 percent on more than half of the questions about how well a given patient’s doctor communicates, coordinates care, and knows him or her as a patient. But a few of the group practices score well below average on several measures, including how well doctors give preventive care and advice.<sup>14</sup>

**“Some state payment commission members point to Mount Auburn’s successes as proof that global payments could work in Massachusetts.”**

### Extending Global Payments Statewide

All in all, despite the mixed results, some state payment commission members point to Mount Auburn’s successes as proof that global payments could work in Massachusetts—and ample reason that they should form the basis of an entirely revamped

payment system. But the panel as a whole was under no illusion that switching to a new payment model would be easy, popular, or swift. For one thing, Massachusetts would need significant help from the federal government—most likely in the form of a waiver—since under the commission’s plan, Medicare and Medicaid payments would also convert to a global budget system. And although the Centers for Medicare and Medicaid Services (CMS) has expressed interest in working with the state on a pilot global payment project, some congressional leaders have been reluctant to let states experiment with Medicare.

Private insurers would also have to be fully on board with the payment switch. Blue Cross of Massachusetts, the state’s largest private health insurer, is already aggressively marketing global payments, but other insurers have expressed more caution. Perhaps most of all, both health care providers and patients need to be willing to make the change. And given the importance of state-of-the-art health care in Massachusetts’ economy—and psyche—that will be a tall order.

A major issue is how the missions of the

state's preeminent academic medical centers would mesh with a new global payment system. Institutions such as Partners HealthCare have clearly used higher payment rates to help subsidize their missions of teaching and research. Some state business leaders now worry that global payments could stifle research and innovation at these institutions that provide jobs and fuel the area's biotech industry. Assuming that global payments standardized rates across the state's hospitals, how would those research and teaching missions be financed?

If patients admitted to these and other of the state's teaching hospitals are truly sicker than other patients, one solution would be incorporating that into risk adjustment of global payments. But while Partners CEO James Mongan says he generally supports the move to global payment, current risk-adjustment tools are "flawed" and wouldn't fully reflect these institutions' higher costs. Another solution might be turning to the federal government for support, perhaps through a "trust fund" designed to support academic health centers, as the late Sen. Daniel Patrick Moynihan of New York once proposed. But that could be problematic amid record federal budget deficits and pressures to spend more money to cover the uninsured.

■ **Work in progress.** The Massachusetts payment commission didn't have any solution to these quandaries, so it recommended leaving the question of how to support teaching institutions to a yet-to-be-created global payment "implementation board." The board would also have the responsibility of determining how best to move the state's providers into global payment arrangements in stages. Under the right timetable, says Harvard economist Joseph Newhouse, most of the larger hospitals in Boston and their physician groups could make global payments work. But it would in all likelihood take more time to bring global payments to rural parts of the state, where most doctors are still in solo or small-group practice and have no close links to hospitals or to networks of labs or specialists.

In the end, it will clearly be critical to ob-

tain buy-in among providers statewide that global payments are the way to go—and that they're willing to make changes, give up some autonomy, and possibly forgo some income to keep the burden of health spending sustainable. "Massachusetts will only get the benefit of global payments when it reaches a critical mass of hospitals and doctors who are willing to rethink how they provide care and take steps to reduce unnecessary care," says Elliott Fisher, director of the Center for Health Policy Research at Dartmouth Medical School. "Everyone has to give up something" to achieve the gains, adds Nancy Kane, a professor at the Harvard School of Public Health and a member of the payment commission.

That leaves patients and consumers, who for the most part are only now tuning into the implications of global payments for their health and health care delivery. "The process has been flawed to the extent that consumers have not been at the center" of the discussions, "and that needs to be corrected," says the Reverend Hurmon Hamilton, head of the Greater Boston Interfaith Organization.

The fact is that the bitter memories of managed care still linger—and it's "going to take some considerable protections to make sure that consumers are comfortable" with a wholesale payment change that could be seen as offering incentives to withhold care, says Brian Rosman, research director at the advocacy group Health Care For All in Boston. "Global payments could be very helpful or very dangerous, and we want to make sure [they are] implemented in the right way." Harvard School of Public Health professor Robert Blendon says the state will have to be out front, early, with a clear campaign that stresses the value of better-coordinated care. He suggests that the state could also reassure its citizens by establishing a consumer review board to make sure patients would have a clear, easy way to resolve any complaints about what they consider limited care.

State lawmakers now plan to start drafting legislation to implement the commission's recommendations and to launch hearings on the bill in early autumn 2009. In the meantime,

key lawmakers such as State Senator Richard Moore, the Senate cochair of the legislature's health care financing committee, and Representative Stanley are introducing interim legislation that they hope will build momentum to take on sweeping change. But as the state's major providers push back or counsel caution, it's not clear how quickly reform efforts can progress.

"People are not in a position where they want to leap in," says Mongan, Partners' CEO. "People want to be careful that they've not taken steps in the dark, but that they've gone ahead with their eyes wide open." Mongan says the legislature should take six months or a year to study the challenges of such a major change. Massachusetts residents, after all, can look back on plenty of examples when a major reconstruction project didn't exactly go as planned. Boston's infamous multiyear construction project, dubbed the "Big Dig," turned out to be the most expensive highway project in history and took twenty-five years to complete. Finding ways to restrain the state's health spending without risking chaos is likely to be no less a Herculean task.

*The author acknowledges the help of Elliott Fisher and an anonymous reviewer.*

**NOTES**

1. Massachusetts Division of Health Care Finance and Policy. Health care in Massachusetts: key indicators [Internet]. Boston (MA): DHCFP; 2009 May [cited 2009 Jul 23]. 4 p. Available from: [http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/Key\\_Indicators\\_May\\_09.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/Key_Indicators_May_09.pdf)
2. Seifert MPA, Swaboda MS. Shared responsibility [Internet]. Boston (MA): Blue Cross Blue Shield of Massachusetts Foundation; 2009 Mar [cited 2009 Jul 23] 4 p. Available from: [http://bluecrossfoundation.org/foundationroot/en\\_US/documents/090406SharedResponsibilityFINAL.pdf](http://bluecrossfoundation.org/foundationroot/en_US/documents/090406SharedResponsibilityFINAL.pdf)
3. Massachusetts Taxpayers Foundation. Massachusetts health reform: the myth of uncontrolled costs [Internet]. Boston (MA): MTF; 2009 May [cited 2009 Jul 23]. 2 p. Available from: <http://www.masstaxpayers.org/files/Health%20care-NT.pdf>
4. Kingsdale J. Implementing health reform in Mas-

sachusetts: strategic lessons learned. Health Aff (Millwood). 2009;28(4):w588-94, Note 10.

5. U.S. Census Bureau. Historical health insurance tables. HIA-4: Health insurance coverage status and type of coverage by state—all persons; 1999 to 2007. Washington (DC): Census Bureau; 2007.
6. Massachusetts Division of Health Care Finance and Policy. Unpublished data, based on data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2007.
7. Medical Academic and Scientific Community Organization Inc. Longwood Medical Area fact sheet, 2005 [Internet]. Boston (MA): MASCO; 2007 [cited 2009 Jul 23]. Available from: [http://www.masco.org/aboutLMA\\_facts.htm](http://www.masco.org/aboutLMA_facts.htm)
8. Globe Spotlight Team. A healthcare system badly out of balance. Boston Globe. 2008 Nov 16; Sect. A:1 (top).
9. Fisher ES, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: the extended hospital medical staff. Health Aff (Millwood). 2007;26(1):w44-57.
10. Fisher ES, McClellan MB, Bertko J, Lieberman SM, Lee JJ, Lewis JL, et al. Fostering accountable health care: moving forward in Medicare. Health Aff (Millwood). 2009;28(2): w219-31.
11. Centers for Medicare and Medicaid Services. Hospital Compare (DRG 493) [Internet]. Baltimore (MD): CMS; 2009 Jun 8. Available from: <http://www.hospitalcompare.hhs.gov/Hospital/Search/compareHospitals.asp>
12. Massachusetts Health Care Quality and Cost Council. My health care options [Internet]. Boston (MA): HCQCC; 2008 [cited 2009 Jul 27]. Available from: <http://hcqcc.hcf.state.ma.us>
13. Dartmouth Institute for Health Policy and Clinical Practice. Dartmouth atlas of health care [Internet]. Hanover (NH): Dartmouth Institute [cited 2009 Jul 23]. Available from: <http://www.dartmouthatlas.org>
14. Massachusetts Health Care Partners. Quality insights: 2007 patient experiences in primary care [Internet]. Watertown (MA): MHQP; c2008 [cited 2009 Jul 23]. Available from: <http://www.mhqp.org/quality/pes/pesCatSumm.asp?nav=031648&checkall-on&DOList=1101166&DOList=1101168&DOList=1101173&DOList=1101177&DOList=1101178&DOList=1101179&DOList=1101180&DOList=1101182&DOList=1101183&DOList=1101187&CategoryID=1&Go-Continue>